MENTAL HEALTH FACILITY DESIGNATION WORKSHEET

Facility Name: _____ Clinics at Facility: _____

Clinic Address: _____

County: _____ HPSA Facility Serves (Name/ID): _____

Facility is a community mental health center, public or non-profit: ☐ Yes ☐ No*

☐ Metropolitan ☐ Non-metropolitan ☐ Frontier

1) Provision of Services (one):

☐ More than 50% of facility's mental health care services are being provided to residents of a HPSA.

☐ Within 40 minutes of HPSA and facility is accessible to residents of HPSA (i.e., no socioeconomic differences).

To: _____

Distance by: ☐ Auto ☐ Bus ☐ Other

Source:

☐ Rand McNally Atlas

☐ Maps-on-us

☐ Other:

Road Type:	Miles	Minutes
Interstate 1.33		
Primary 1.6		
Secondary 2.0		
Total		

2) Insufficient Capacity (one):

☐ (i) >=1000 visits per year per FTE core mental health professional.

_____ Number of visits _____ FTE _____ Visits/FTE

☐ (ii) >=3000 visits per year per FTE psychiatrist on staff of the facility.

_____ Number of visits _____ FTE _____ Visits/FTE

☐ (iii) No psychiatrists on staff and this is the only facility providing mental health services to the HPSA.

*Reject application if not a community health center, public or non-profit facility.

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Applicant Reminders:

☐ Map with boundary of HPSA, location of facility, and route from HPSA population center to facility.

☐ FTE Spreadsheet, if applicable

Applicant Requests:

☐ Designate ☐ Continue ☐ Reinstate

Rational:

☐ Meets criteria ☐ Other

Signature: _____ **Date:** _____

Notes: _____